AFFIDAVIT OF HESTAL LIPSCOMB

EXHIBIT A

CHRISTIANA CARE HEALTH SERVICES

☐ Christiana Hospital
4755 Ogletown-Stanton Rd.
Newark, DE 19718

☒ Wilmington Hospital
501 W. 14th Street
Wilmington, DE 19801

Phone ...(302) 733-1900

Date: 4/9/03

℞ # _____

Med. Allergies: _____

Circle Refills Limit 1 yr

NAME LIPSCOMB HESTAL

ADDRESS REDACTED

MRN

B.D.

ONE RX PER BLANK

1 Please excuse Ms. Hestal Lipscomb
2 from work 4/4/03, and after this
3 so that she can undergo surgery.
4 pt may return to work 4/14
5

NO REFILLS FOR SCHEDULE II DRUGS

DISPENSE AS WRITTEN

AW2401507 -
AT2887175 - GS0100
Resident DEA ... - (SUFFIX)

Benjamin Eskra, M.D.

B. Eskra MD

SUBSTITUTION PERMITTED

(SIGNATURE)

AFFIDAVIT OF HESTAL LIPSCOMB

EXHIBIT B

To whom it may concern: 04/19/04

Ms. Hestal Lipscomb has been scheduled for outpatient surgery on 4/29/04 at Wilmington hospital. Please contact Surgical Services @ 428-4413 if any question.

Chief Surgical Resident
Jonathan Kraut, MD

Surgical

AFFIDAVIT OF
HESTAL LIPSCOMB

EXHIBIT C

CHRISTIANA CARE
HEALTH SERVICES

Wilmington Hospital Health Center

Date 5/10/04.

Lipscomb, Hesta was seen in

at the Wilmington Hospital, Surgical Clinic

services on _____.

May return to School/Work on 5/17/04.

Remarks: May Return to Work
ON Above Date

_____

Any questions, please call 428 - 4413.

16177 P (39371)(0898)

EDS II 00033

AFFIDAVIT OF
HESTAL LIPSCOMB

EXHIBIT D

DELAWARE DEPARTMENT OF LABOR
KEEPING DELAWARE FIRST

AT (302) 761-6636

903-79-2456

DIVISION OF UNEMPLOYMENT INSURANCE

CLAIMANT'S AUTHORIZATION FOR RELEASE OF INFORMATION/ DOCTOR'S CERTIFICATE

Claimant's Name: Hestal Lipscomb **REDACTED**

Claimant Signature: Hestal Lipscomb Social Security#

TO THE PHYSICIAN: The claimant's (your patient's) signature on this document authorizes you to respond in writing to the following questions thus constituting a waiver, by the claimant, for this purpose only of the physician-patient privilege. Please be advised that the information requested on this certificate will be used to determine your patient's entitlement to unemployment insurance benefits. Accordingly, it is essential that the information provided on this document be as complete and accurate as possible. Since benefits cannot be paid without this documentation, your timely response is appreciated to avoid delayed payments to your patient. If mailing this form directly to our office would be more expeditious, our mailing address and fax number is listed on the reverse side of this certificate.

1. Patient's Name: Hestal Lipscomb has been under my care from 4/7/04 to 5/10/04
2. Nature of ailment: **REDACTED**
If prenatal/postnatal care, expected date of childbirth: N/a actual date of childbirth:
3. Was patient advised to quit last job for reasons of health? ☐ Yes ☑ No
If "Yes", give suggested last date of work:
4. If answer to question 3 is "No", was patient advised to be absent from last job due to health? ☑ Yes ☐ No
If "Yes", give suggested dates of absence: 4/29/04 - 5/17/04
5. Is the patient totally disabled from performing the duties required in his/her current occupation? ☐ Yes ☑ No
If "Yes", date of disability: from to
6. If patient cannot perform regular duties, have/will you permit performance of any other work on a full-time basis?
☑ Yes ☐ No
If "Yes", specify type of work, together with work limitation, if any: No limitation
If "Yes", specify date patient was/will be able to perform these duties: 5/18/04
7. Comments:

CERTIFICATION: *As a duly authorized practitioner of medicine, I have issued this certificate with full knowledge that it will be used by the Department of Labor to make a determination of eligibility for unemployment insurance benefits under the provisions of Title 19, of the Delaware Code. I certify that the information provided by me is a true representation of the patient's medical condition as it relates to his past employment and/or current state of health.*

Physician's Name (please type or print): Medhi Jadali, MD

Physician's Signature: Medhi Jadali

Physician's Address: Wilmington Hospital Health Center
Surgical Clinic 501 W. 14th St.
Wilmington, DE 19801

Date: 8/12/04

Office Phone#: (302) 428-4413

Office Fax #: 428-6403

HL-089

UC-500B
Doc No 60 06 01 04 05 01

CERTIFICATE OF SERVICE

I hereby certify that on this 3rd day of July 2006, I caused a copy of the foregoing AFFIDAVIT OF HESTAL LIPSCOMB to be served on the following counsel of record via hand delivery:

Alyssa M. Schwartz, Esquire
Richards, Layton & Finger, P.A.
920 King Street, P.O. Box 551
Wilmington, DE 19899-0551

/s/ Laurence V. Cronin
Laurence V. Cronin (ID No. 2385)